PHILADELPHIA MEDICAL TIMES.

SATURDAY, DECEMBER 26, 1874.

ORIGINAL LECTURES.

CLINICAL LECTURE ON SCABIES.

Abstract of a Lecture delivered at the Hospital of the University of Pennsylvania

BY LOUIS A. DUHRING, M.D.

Reported by ARTHUR VAN HARLINGEN, M.D.

GENTLEMEN,—Before examining this patient we will obtain from him a few facts relative to the beginning of the complaint from which he suffers, and also some account of its course. He is an Englishman, healthy, and has never had any disease of the skin previous to that for which he now seeks relief.

When he landed in New York, six months ago, he was, to the best of his knowledge, perfectly well. He spent two nights in a boarding-house in that city, and then came to Philadelphia. Three weeks after his arrival here he first noticed an eruption on the left fore-arm, characterized by itching. This spread gradually from one point to another until pretty much the entire body, with the exception of the face, palms of the hands, and soles of the feet, became involved. Lately the itching has been so severe as to keep him awake all night: indeed, he tells us he is often obliged to stupefy himself with liquor in order to gain a night's rest.

Such are the facts in the history of the case. Now, proceeding to examine our patient, we first observe that the disease is a chronic one. We do not need the history to acquaint us with this fact; any one who has had much experience in this class of cases would immediately perceive the disease to be non-acute. This patch, for instance, can easily be known to have existed some time. We have here numerous old scratch-marks, the result of long and habitual use of the nails. Let me remind you just here that the presence or absence of the evidences of scratching should always claim your attention in the examination of diseases of the skin. Such evidences will decide at once whether the affection under consideration belongs to the class of itching or non-itching diseases. The case before us evidently belongs to the former; even such remote parts of the body as the integument covering the angles of the scapulæ, which are quite difficult to reach, have been attained by long practice on the part of our patient.

As to the localities affected, you will observe that though the disease extends pretty much over the entire body, yet there are certain parts where the process seems to have been more active, as evinced by the greater number of scratch-marks. The regions about the axillæ, for instance, have been very much scratched. Some of these marks are quite florid,—they are recent; others are darker and older. About the nates the disease appears to have been particularly troublesome. We notice here that the corium has become considerably thickened, and many large pustules are scattered over it.

Along the thighs also the scratch-marks are very numerous, and the skin is sprinkled over with crusts, not of dried pus, however, but of blood. We have here, also, broken hairs and torn follicles, from each of which a drop of blood has oozed.

All these appearances result from the scratching; and I dwell upon these marks because they play an important part in the history of the case. Before leaving this point, observe that the inside of each thigh presents the disease in a still more marked form. We have here pustules, scales, pigment-spots, and patches of infiltration, which will endure some time after all active symptoms of the disease have disappeared.

Taking a general view of the case as the patient stands before us, notice the peculiar arrangement of the eruption: plentiful in the axillæ and on the buttocks and abdomen, less so on other parts of the body, notably the sternum. On the palms of the hands and soles of the feet, as well as on the face, absolutely no trace of the affection can be discerned.

The differential diagnosis of the case lies between two diseases: simple eczema, and scabies or "the itch." These two affections are the only ones likely to assume the appearances here presented. Remember that when I speak of scabies as "the itch," it is not merely an itching disease to which I allude, but one of a parasitic nature, dependent upon the irritation and inflammation produced by an insect, the acarus scabiei.

A single point shows us almost certainly which of these two diseases we have before us, and that is the arrangement of the eruption. On the one hand, we have it more marked over the axillæ, abdomen, buttocks, and thighs,—all parts of the body well protected with clothing. On the other hand, the eruption is very scanty over the sternum, and does not exist at all on the face, palms, and soles, all of which are localities either greatly exposed to external influences, or which, from their structure, are unfavorable to the morbid process.

In short, the eruption affects those parts of the body best suited to the unhindered development of the itch-insect, and we have before us a case of scabies. Were this eczema, we would have the eruption more irregularly distributed; eczema has no places of election. The diseases in appearance, however, resemble each other closely, and in fact the result of the irritation of the itch-insect is eczema of one form or another; but it is a result, and not the primary lesion. Cases of eczema papulosum are often mistaken for scabies, and the patients reported cured by internal treatment, etc.

The only reliable diagnosis, after all, is based upon the presence or absence of the itch-insect itself, the acarus scabiei, which must be carefully sought for in such parts of the skin as it is most likely to be found in. One of these localities is the hand, and particularly the skin on the inside of the fingers. At this point the burrows in which the acarus lies are less likely to be torn open, and may also be seen more distinctly than elsewhere. When patients work in strong alkalies, acids, or the like, these

burrows become destroyed, and are then very frequently not found or are altogether absent.

The burrows of the itch-mite are worthy of careful study. They are produced by the insect finding its way under the epidermis and then making a canal or passage which is seen upon the surface as an elevated line or ridge about a quarter of an inch long, usually dark-colored or black, owing to accumulations of dirt and foreign substances which are apt to collect upon the hands.

The burrows are about half a line in width, and vary in length; sometimes they are but a line or two, in other cases they are as much as half an inch long. They are found in greatest number, perhaps several or more, upon the insides of the fingers near the hand, where the skin is thinnest. Here the mites make their habitat, and are apt to remain undisturbed until they have deposited their eggs, when they are known to die in their burrows.

There are very few entire burrows on this man's hands, owing to the fact that the disease is chronic, and the long-continued scratching and tearing to which the skin has been subjected has caused them to become rubbed down, broken, torn, and scraped off, and finally, to a great degree, obliterated. Still, there are some left, and by carefully searching these the insect may be detected and picked out. We need not expect to find a dozen in this hand; we shall be fortunate if we find two or three.

In order to obtain the acarus, we take a needle, and, opening the closed end of the burrow, which is indicated by a black dot, and which is the point where the insect lies, we may be able, if dexterous, to lift it out upon the needle-point. The operation must be performed very carefully, otherwise the wrong end of the burrow may perhaps be picked, and a drop of serum exuding will swamp the acarus beyond all hope of recognition. The parasite, you must remember, is exceedingly small,—scarcely the one-thirtieth of an inch in diameter,—and of a color and transparency almost those of serum itself. You must be careful, therefore, I repeat, or you will almost certainly fail to obtain it.

It is the female acarus which burrows in the way I have described, in order to deposit its ova. The male insect crawls about over the surface of the skin, and may be detected with the aid of a lens by those who are more than usually fortunate. He is exceedingly difficult to find.

Scabies is a very rare disease in Philadelphia, on account of the well-known habits of cleanliness to which our people are accustomed. A comparatively small number of the inhabitants of this city live crowded together in tenement-houses, and bathing is frequent. Besides this, comparatively few emigrants arrive at this port, while in other cities, as Boston and New York, whole ship-loads are frequently emptied into the population, bringing the disease with them and spreading it in all directions.

The consequence is that scabies is much more common in those cities than in Philadelphia, and you will find ten or twenty cases in New York to one here.

I will not give you at this time the treatment of scabies in general, but merely the plan which we shall pursue in the present instance, which is as follows:

Let me begin by advising you, whatever application it may be of which you make use, not to make it too strong. Were we to employ the officinal sulphur ointment, for instance, in this case, containing as it does four drachms of sulphur to the ounce of lard, we should make the patient's condition worse for the time than before, since an artificial irritation would in all probability be set up. He already has eczema from severe and long-continued irritation of the skin, and any strong application would only tend to aggravate the inflamed skin.

We shall, therefore, in the present instance, make use of the following formula:

℞ Flor. sulphuris,
Bals. Peruvian., āā ʒii;
Adipis, ʒiv.—M.

This ointment is to be thoroughly worked into the affected portions of the skin every morning and evening for four days. If this has been thoroughly done, the scabies itself will by that time be cured, and there will remain only the artificial eczema produced by the presence of the acarus. This, the cause having been removed, will probably get well spontaneously, nothing more being needed than bathing. You must not expect, in a case like this, that all itching will cease the moment the disease is put an end to. The mere nervous excitability brought about by long-continued sleeplessness and irritation will not at once subside. We shall, however, expect that, when this patient appears before us a week hence, most of the itchiness shall have subsided, and that he shall enjoy a good night's rest.

It will be some time, however, before all traces of the eczematous eruption shall have disappeared, and it may be necessary to hasten this result after a few days by such an ointment as the following, to be applied morning and night, after bathing:

℞ Acid. carbolic., gr. x;
Ung. zinci ox. benz., ʒii.—M.

ORIGINAL COMMUNICATIONS.

STRYCHNIA IN ATROPHY OF THE OPTIC NERVE.

BY GEORGE C. HARLAN, M.D.,
Surgeon to Wills Ophthalmic Hospital.

AS the value of strychnia in the treatment of amaurosis may still be considered, to a certain extent, *sub judice*, or as, at any rate, its use is by no means so general yet as it might be, the report of a few cases in which it has been given a faithful trial may not be out of order.

Though the records of ophthalmic literature show that strychnia has been used in this disease occasionally and in a desultory way for years, principally by means of applying the powder to blistered surfaces on the temple, or by rubbing it in the form of oint-

ment about the brow, perhaps to Nagel belongs the credit of having, in 1871, reintroduced it, employed it rationally and systematically, and given it a recognized place in ophthalmic therapeutics.

Nagel, in all his cases, administered the drug by subcutaneous injection, and selected the temple as the place of its introduction; and, with few exceptions, all other surgeons who have adopted the treatment have followed the same plan.

Gori, of Amsterdam (*Annales d' Oculistique*, July and August, 1872), gave it as the result of his experience that this treatment might effect decided improvement even in cases where the loss of vision was accompanied by evident anatomical changes, but that the mode of administration insisted upon by Nagel was not essential. To avoid the inconveniences that sometimes resulted from frequent hypodermic injections, he dissolved the nitrate of strychnia in tincture of iodine, and painted it daily on the temple and around the orbit, and claimed that this method was equally efficient.

Dr. C. S. Bull, of New York (*Am. Jour. Med. Sciences*, April, 1873), gives decided preference to hypodermic injection, but thinks it a matter of no importance what point is selected for the operation, and chooses the fore-arm as a matter of convenience.

Dr. Chisolm, of Baltimore, who has contributed several interesting articles on the subject to the same journal, and who was, I believe, the first to call attention to it in this country, began with hypodermic injections in the arm, but was afterwards convinced that identical results could be obtained by internal administration.

A matter of great practical interest is the dose that should be given. This has shown a decidedly upward tendency. Nagel used subcutaneous injections of from one-fortieth to one-thirty-second of a grain, repeated daily or at intervals of one or two days, during periods of from a few days to three or four weeks; but much larger doses seem to be now very generally considered necessary. Indeed, it may be considered to be pretty well decided that the treatment has not had a fair trial in any case in which the remedy has not been pushed to the largest dose that the patient can comfortably or safely bear.

Dr. Chisolm, in his first report (January, 1872), says, "I commence usually with one-sixtieth of a grain, which I gradually increase to one-thirtieth twice a day (by hypodermic injection), in no case exceeding this last amount." In his last article (April, 1873) he gives it as the result of his extended experience that one-half grain daily, administered internally in divided doses, produces the best remedial effects.

He thinks that when these large doses have secured a tolerance, they may be safely continued for months, or may be even still further increased should they lose their effect. He tells us that the maximum dose can be attained in from fifteen to twenty days, but gives us no means of discovering at what time he has found the maximum curative effect to be produced. Dr. Chisolm has not given his cases, but only his general conclusions, and it is to be regretted that he has not been more definite on this point. Though detailed notes of cases make sadly dry reading, they often make also the most reliable and useful kind of statistics.

In the seventeen cases reported by Dr. Bull, the period of treatment varied from six days to three months, and the maximum dose from the one-fortieth to the one-tenth of a grain of the nitrate, injected in some cases daily and in others every other day. He concludes that when we do not see any improvement after the first three or four injections, not much advantage is to be expected from its use. I am not quite inclined to agree with him in this, though his experience has been much more extended than my own.

In three very successful cases recently reported by Dr. H. Derby (*Boston Med. and Surg. Journal*, November 5, 1874), the periods of treatment were from four to ten weeks, and the maximum dose was in one case one-eighth, and in the other two one-fourth of a grain of the nitrate, injected in the temples at intervals of several days.

In my own cases, sometimes the sulphate in solution and sometimes the alkaloid in sugar-coated granules was given continuously in gradually-increasing doses, until decided symptoms appeared or improvement ceased. The maximum daily dose varied from one-fourth to one-half grain, and the periods of treatment from two to ten weeks. Perhaps the maximum dose might with advantage have been reached more quickly in some of the cases and have been increased in others.

In regard to the mode of administration, my belief is that it is a matter of little moment whether the nitrate, the sulphate, the acetate, or the alkaloid is used, or whether it is injected in the temple or the arm, or given by the stomach, provided the system be brought thoroughly under the effects of strychnia. I would not suspend the use of the drug until a decided effect had been produced, or be disposed to continue it long afterwards unless the improvement in vision still progressed, which has not occurred in any of my cases.

A good deal has been written about the particular conditions of the nerve to which this treatment is applicable; but my limited experience rather confirms the impression derived from the study of the practice of others, that it rests entirely on empirical grounds, and that the ophthalmoscope furnishes no reliable data for deciding whether strychnia is likely to be of use or not. Though it may be said, in general terms, that those cases offer the greatest hope of improvement in which there is least evidence of anatomical change, even this rule is by no means without exceptions, as is shown by the fortunate result in Case V. In this case it was evident, both from the previous history and the ophthalmoscopic appearances, that the condition of the nerve was the result of inflammatory changes.

Only one of my cases belonged to the class to which Dr. Derby calls attention as being particularly amenable to this treatment. I allude to the form of disease called "tobacco amaurosis," or "alcohol amaurosis," or more comprehensively, and perhaps more correctly, as those who drink or smoke to great excess are likely to be generally regardless of sanitary laws, "amblyopia ex abusu."

Dr. Schoen (*Annales d' Oculistique*, September and October, 1874), considering the pathology of these cases to be, in the commencement at least, retinal anæsthesia, has prescribed santonin, and claims that it has given him even better results than strychnia.

In the mysterious form of amblyopia that is often met with in hysteria I have tried strychnia only once, and with no other effect than a violent headache, a decided increase of "nervousness," and general discomfort. I have not thought it worth while to try it in cases where vision was entirely lost, or where a high degree of amblyopia had existed for a long time; nor have I had any experience, as yet, in its use in amblyopia from disuse, though others have obtained excellent results in the latter class of cases.

As the best way of showing the progress of the cases and its relation to the increasing dose, I give the following extracts from the hospital records.

Case I.—J. F., a day-laborer, aged 62, stated that his sight had been failing for two years, but that he had found out, by accident only, six months before, that the left eye was quite blind. In the right eye there was vision of $\frac{20}{80}$ (that is, he could distinguish No. 80 only of Snellen's test-types at twenty feet, instead of No. 20, and consequently had only one-fourth the average acuteness of vision). In the left eye there was complete white atrophy of the disk, and no perception of light. In the right the atrophy was evident, but not so advanced. There was some central limitation of the field of vision. The pathology of the case was obscure. It seemed to be one of simple progressive atrophy, as there was no sign of local inflammation and no history of cerebral symptoms.

Treatment was commenced, October 20, by one-twenty-fourth grain of strychniæ sulph. given internally three times a day. This was continued until November 7, without improvement.

November 7.—V = $\frac{20}{80}$; ordered four-twenty-fourths grain daily.

November 17.—V = $\frac{20}{60}$; ordered three-twelfths grain daily.

November 26.—V = $\frac{20}{50}$? (doubtful); ordered three-twelfths grain daily.

December 3.—V = $\frac{20}{40}$? (doubtful); ordered three-twelfths grain daily.

December 15.—V = $\frac{20}{40}$ distinct, and some letters in XXX.

December 22.—Had continued to take three-twelfths grain daily, but without further improvement; and, though there was no muscular spasm, he had a good deal of headache and malaise, and treatment was discontinued.

Case II.—O. M. was entered on the record as a case of "tobacco-amaurosis." He was a shoemaker, and had been in the habit of smoking a pipe, while at work, the greater part of the day. His sight had been gradually failing for about nine months, and for some weeks he had been obliged to give up his work entirely. The external appearance of the eyes was natural, except that the pupils were slightly dilated and moved sluggishly. His vision was only $\frac{1}{100}$ in each eye, little more than enough to enable him to go about without assistance. The ophthalmoscope showed nothing abnormal but a slight blanching of the disks.

March 20.—V = $\frac{1}{100}$; ordered strych. sulph., three-thirty-seconds grain daily.

March 31.—No improvement. Ordered strych. sulph., four-thirty-seconds grain daily.

April 6.—V = $\frac{6}{100}$ in R, $\frac{6}{80}$ in L; ordered strych. sulph., five-thirty-seconds grain daily.

April 13.—V = $\frac{6}{80}$ in each; ordered strych. sulph., three-sixteenths grain daily.

May 13.—V = $\frac{6}{50}$. Had omitted the medicine for some time. Commenced again with three-twenty-fourths grain daily.

May 18.—Ordered three-eighteenths daily. May 21, three-sixteenths. May 27, four-sixteenths.

May 29.—V = $\frac{8}{40}$? Ordered to continue four-sixteenths, though there was slight spasm. June 1, five-sixteenths.

June 8.—V = $\frac{8}{40}$ distinct. Ordered three-eighths grain daily.

June 15.—V = $\frac{8}{30}$; ordered one-half grain daily.

July 1.—V = $\frac{8}{20}$; ordered to continue.

July 6.—V = $\frac{10}{20}$, which enabled the patient, with convex glasses, to return to his work without difficulty. The improvement in vision in this case is represented mathematically by the difference between the fractions one-twenty-fifth and one-half.

Case III.—M. O., aged 22, could see to read until she was fifteen years of age, and then her vision gradually failed. She was excessively nervous, and subject to "spells" which, from her account, seemed to resemble catalepsy.

The ophthalmoscope showed bluish-white atrophy of disks, and indications of old choroiditis. Strychnia was administered, commencing with one-twenty-fourth grain three times a day, and gradually increased to one-twelfth, when symptoms of poisoning appeared, and treatment was suspended at the end of two weeks. No improvement.

Case IV.—C. K., 33 years of age, stated that six or seven years before, he had had typhoid fever, and had been subject to frontal headaches since; that he had occasional attacks of dimness of vision immediately after the sickness, and that about one year ago the dimness commenced to increase rapidly, and became permanent. When he came to the hospital there was barely enough sight left to enable him to go about the streets alone. In the right eye there was entire obliteration of the inner side of the field, and he could count fingers, with difficulty, in the outer half. With the left he could distinguish the letters of No. 70 at one foot in the centre of the field, and only No. 200 at either side. The ophthalmoscope showed decided blue atrophy of the disks, though the retinal vessels were not very much diminished in size. Treatment was commenced July 9 with one-tenth grain daily, the dose being gradually increased at intervals of a few days.

August 24.—He had been taking two-fifths grain daily for five days, and his vision had increased in the left eye from $\frac{1}{70}$ to $\frac{1}{40}$? Not much improvement in the right.

August 31.—Had been taking one-half grain daily since the 27th, without further improvement. As he complained of headache and muscular spasm, treatment was discontinued.

Case V.—E. H., about 20 years of age, the daughter of a farmer in the interior of the State, had been in the hospital more than a year before. She had, at that time, well-marked optic neuritis, with engorgement of the retinal vessels, but without "choking" or decided swelling of the disks. The neuritis was evidently of cerebral origin, as it was accompanied by paralysis and other unmistakable symptoms. Under the use of mercurial inunction, iodid. potass., and quinine and iron, her vision had risen from $\frac{1}{200}$ to nearly $\frac{20}{20}$ when she was discharged. At the time of her re-admission there was still slight hemiplegia, and her vision had fallen to $\frac{1}{80}$. The retinal vessels were contracted, the disks were whitened, and there was perceptible atrophic cupping. Strychnia was administered, in gradually increasing

doses, until it had to be discontinued on account of the sudden appearance of alarming symptoms of poisoning. When she recovered she was delighted to find that her sight had greatly improved, and that she was able, with comparative ease, to read a letter from home, which had been utterly impossible before.

Five months afterwards, she wrote that the improvement in her vision had been permanent, though her other symptoms had grown much worse. The following record is from the notes of the Resident Surgeon, Dr. J. A. Lippincott, who watched the case with great interest and care:

"June 5, V = $\frac{4}{80}$; ordered strychniæ sulph. three-thirtieths grain daily; June 12, ordered three-twenty-fourths grain daily; June 16, three-twentieths grain; June 22, three-sixteenths grain; June 27, three-fourteenths grain; July 2, three-twelfths grain; July 8, three-tenths grain: still no improvement.

"July 12, V = $\frac{5}{80}$; ordered three-eighths grain daily.

"July 16, V = $\frac{6}{80}$; ordered three-sevenths grain daily.

"July 21, V = $\frac{7}{80}$; ordered three-sixths grain daily.

"Complains of inability to speak distinctly, from stiffness of the tongue.

"July 24.—V = $\frac{14}{80}$. Taken in the evening with spastic contractions of the voluntary muscles, accompanied by delirium of an hysterical character. Stop strychnia July 31.

"The symptoms above mentioned continued for the past week, intensified at night, and requiring large doses of morphia and chloral to subdue or moderate them. Chloroform by inhalation was tried, but with merely transient benefit. This morning the patient is rational, and screamed with delight on finding herself able to read the address and contents of a letter that was handed to her. Can read No. 3 Snellen with ease, and No. 2½ with some effort. Resumed the strychniæ sulph., in doses of three-sixteenths daily.

"August 8.—No further improvement; discharged."

A point of great interest in this case is the fact that improvement did not commence until the patient had been under treatment more than a month and the dose had been increased to three-eighths grain, and did not reach its maximum until she had been brought thoroughly, and, as we feared, dangerously, under the influence of strychnia.

DISLOCATION OF THE HEAD OF THE FEMUR FORWARD ON THE PUBIC BONE.

BY J. R. SHELLENBERGER, M.D.,
Mt. Airy, Philadelphia.

THE accident occurred in a gentleman aged 64 years, in good health, and with well-developed muscles. He stood by the side of a rapidly-moving train, and with his left hand caught the iron railing, and at the same time put his left foot on the step. He was violently swung upon the platform, and, recovering himself, found his right foot turned outward, and judged at once that dislocation had taken place.

I saw the gentleman twenty minutes after the receipt of the injury, and found him entirely unable to walk, and in great pain. On examination, the limb was three-fourths of an inch shorter than the left, the foot and knee turned outward. The head of the femur could be distinctly felt upon the ramus of the pubes, outside of the femoral artery, both being very prominent.

The reduction of the case was extremely difficult. The patient was thoroughly etherized, and three separate times during the day manipulation and the pulleys were tried, but both failed, though most persistently and conscientiously applied. Twenty-three hours after the accident, after a full dose of morphia and a good sleep, it was reduced by manipulation alone, Drs. Agnew, Hunt, Darrach, and Cooper having all been called in consultation.

The patient was placed upon a table, and his hips fixed by binding him to it with a folded sheet. Then, by flexing the thigh until the trochanter major rested just beneath the anterior superior spinous process of the ilium, a fulcrum was made of the latter bone and the head pried out from the pubic bone, when, by a sudden inward rotation, the head glided down; but, instead of entering the acetabulum, it went around that cavity upon the dorsum of the ilium. From this position, however, it was easily dislodged by flexion, outward circumduction, and outward rotation, when it readily slipped into the socket. No inflammation followed, and the patient at present writing, three weeks after the accident, is doing remarkably well.

Prof. Gross says, "The pubic dislocation is an extremely uncommon one, and might, therefore, almost be classed among the rare forms of the accident." Rare indeed, when surgeons of forty years' experience have not met with a case of the kind!

Sir Astley Cooper's experience was that out of twenty cases of dislocation of the hip, twelve were on the dorsum of the ilium, five in the ischiatic notch, two in the foramen ovale, and but one on the pubic bone.

ARSENIC AS A REMEDY FOR ASTHMA.

BY GEORGE ROBERTS, M.D.

IN the *American Journal of the Medical Sciences* for January, 1874, attention was called to the use of arsenic in asthma. I have had under my care the past summer a case of long suffering,—a lady who had moved to Wisconsin, Minnesota, and finally to Nebraska, to obtain relief by the change of air.

Mrs. H., aged 50 years or more, Norwegian, asserted that she had not been able to rest in the recumbent posture for more than a year. It was midnight when I called, April 1. The paroxysm was relieved by chloroform,—the patient sleeping.

The following day Fowler's solution was administered, gtt. v three times a day, and continued with no bad symptoms. After the third day the patient was so much relieved as to be able to attend to her household duties.

Having a troublesome cough, a mixture containing potass. cyanid. and morph. acet. was given, which relieved her.

It is now Nov. 23; the patient is robust and apparently well, with no tendency to asthma. She occasionally has a slight cough.

CREIGHTON, KNOX CO., NEBRASKA.

A WRITER in the London *Lancet* asserts that the constant use of powdered charcoal as a dentifrice will produce a blue line on the gums closely simulating that of lead-poisoning.

NOTES OF HOSPITAL PRACTICE.

PHILADELPHIA HOSPITAL.

SERVICE OF DR. H. C. WOOD.

Reported by JOS. BERENS, M.D., Resident Physician.

CEREBRAL HYPERÆMIA.

GENTLEMEN,—I will occupy the remaining few moments of my hour by saying a few words about a case that terminated fatally in the hospital a few nights since. The notes of the case are these:

Jane McG. was brought to the hospital in the evening of the 8th of October. She had spent the previous night in a station-house, where, during her stay, she had had a number of epileptic convulsions. Her history is that of a hard drinker and degraded character generally. It was also ascertained that she had never been subject to epileptic attacks previously. When first seen in the ward, she presented the appearance of a person in a drunken stupor: face deeply flushed, carotids pulsating violently, head hot, eyes staring, pupils dilated and not sensitive to light, conjunctiva almost without sensibility, pulse 112, hard, bounding, and full, respiration 33 to 36 per minute, deep, and somewhat stertorous in character, temperature 106°. Stupor so profound that she could barely be roused to make an ineffectual effort to put out her tongue, which was dry and brown. There was a contused wound of the scalp, two inches long, and penetrating to the skull, which was not fractured. She received two drops of ol. tiglii, and, this not proving effective in three-quarters of an hour, the dose was repeated. During the next hour she had five epileptic convulsions, which were very violent, lasted about a minute, and were not followed by anything akin to sleep except in the first instance.

An hour after the second dose of ol. tiglii, it had produced no evacuation, and a large injection of soap-and-water was given. This was followed in a few minutes by the discharge of an enormous amount of fæces. Ice to the head, mustard to the feet, and turpentine stupes were now applied, and she was given sixty grains of bromide of potassium. In twenty minutes the temperature had fallen to 104½°, but there was no corresponding amelioration of the other symptoms. During the next two hours she had eleven convulsions, all very violent. Another dose of sixty grains of bromide of potassium was administered. At the end of the next hour there had been four more convulsions, but the pulse had fallen to 93, and the temperature to 102½°; in addition, the patient began to perspire freely. During the following hour the pulse fell to 90, and was much softer and more normal in quality. The general symptoms also lacked in a marked degree the sthenic type which had characterized them at first; the patient seemed more conscious; there was but one convulsion. A thirty-grain dose of bromide of potassium was administered. During the next hour the temperature fell to 101°, the pulse remaining at 90. The patient still perspired copiously; there was but one convulsion.

The following hour was marked by a general change for the better; pulse 88, temperature 101°, respiration quiet, perspiration much less excessive. Pupils and conjunctiva both quite sensitive. At 5 A.M. (Oct. 9), an hour afterwards, the temperature was 100°, and the case seemed to be progressing favorably. Fifteen grains of bromide of potassium ordered every two hours, with continuation of ice to the head. At 7 A.M. the temperature was 102°, pulse 98, skin dry. Ordered a weak milk-punch, with other treatment. At 2 P.M. the pulse was 120, respiration 44, temperature 104½°.

At 7 P.M., temperature 105°, pulse 180, respiration 60.

At 12 M., temperature 106°, pulse 160, respiration 70. Patient in a reeking sweat, which saturates even the blankets on which she lies.

At 12.15 P.M., patient died without a struggle.

Now, what was the matter with this patient? In convulsions accompanied by unconsciousness, the cause may be set down as cerebral. These convulsions were not hysterical, as the temperature was too high; for the same reason they were not due to chronic epilepsy, as is also shown by her previous history; and, on the same authority, we are justified in saying they were acute; the temperature also excluded the diagnosis of uræmia and of alcoholic poisoning, for it has been repeatedly and satisfactorily proved that in both of these the temperature is lower than normal. The convulsions, however, were undoubtedly epileptiform, and in such convulsions accompanied with high temperature the cause is usually found to lie in the onset of an exanthematous or blood-disease, or in an inflammation about the brain.

Thus, when she first came in, the question lay between cerebral inflammation and intense systemic fever, and to decide which of these was all that was necessary for treatment. In this connection, gentlemen, I wish to impress upon you the necessity of learning to regulate your treatment by general principles, and not to hesitate to act in the absence of a definite diagnosis. All of you, in the course of your future practice, will meet with cases where an exact diagnosis is impossible, yet where prompt and efficient action is requisite to preserve life. Under such circumstances you must use your common sense in adapting the therapeutic weapons at hand to the emergency before you, and feel no trepidation because you cannot fix a name to the train of symptoms you are called upon to combat.

But in this case what was to be done? If the case was one of blood-poisoning, the patient ought at once to have been put in a cold bath, or subjected to some other mechanical means for withdrawing heat, as this should always be done in cases of exanthematous diseases with severe nervous symptoms, when the temperature is above 105°. If the case was one of acute cerebral inflammation, bleeding would have been the proper course, and of very necessity this would have lowered the temperature. But here is a dilemma. If in the high temperature of exanthemata we bleed, the chances are that we will kill our patient. If, on the other hand, the same temperature exist in cerebral hyperæmia, and we *do not* bleed, the patient will probably die. But convulsions in the adult are rare in exanthemata; in addition, there was the wound of the head, which indicated a possible cause of inflammation. Moreover, the pulse is stated to have been hard and full,—not the full gaseous pulse of a blood-disease, but the full strong pulse of intense inflammation. Unfortunately, I did not see the patient until the day after her admission, when it was too late for any treatment. If I had seen her when she came in, I perhaps would have bled her. And, gentlemen, once you make up your mind bleeding is the proper thing to do, especially in such a case, bleed for *effect*, and not by *quantity*. Take twenty, thirty, or forty ounces, till what you desire to effect is accomplished. In all cases of intense sthenic inflammation, as of the brain, the peritoneum, etc., if you do not bleed at once and thoroughly, you will often lose patients whom you might have saved.

The brain before you is from the case we have just been discussing. You will observe here, what very often happens, that even the most intensely-marked cases of cerebral hyperæmia often leave comparatively few post-mortem traces behind them. Here the brain-substance seems perfectly normal; the meninges also show but little congestion, except in one place, on the anterior left lobe, in a position on the other side of the skull from and opposite to the wound of the head. The intense

congestion here indicates that this has been one of those cases where the shock received at one point on the head has been transmitted and expended itself at a point directly opposite.

COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

SERVICE OF PROF. WILLARD PARKER.

Reported by J. M. HARVEY, M.D.

CASE I.—A. B., aged 55, has tumors in different parts of his body, on back, arms, knees, and feet. His general health is and always has been good; never had any disease; he knows of nothing to cause this trouble. He says he cannot move his toes; has lost the power of voluntary motion in them.

This case, gentlemen, is a very unusual one. The first question is, What kind of tumors are these? All tumors are divided into two classes,—benign and malignant. To which class do these belong? They are not cancerous or malignant, they are benign tumors.

The man is healthy; he has no syphilitic or any other taint; and these tumors have existed for five or six years, giving rise to the natural inference that they are benign. Such inference is not, however, always correct. A patient once came to me with a tumor which he had had for nineteen years. It gave him no trouble until within six months of my seeing him, when it commenced to be painful. I removed it, but the tumor returned again; it became malignant after having existed as an apparently benign tumor for nineteen years.

Next comes the histological test. What is the character of these tumors? Are they bone, fibrous, or cartilaginous? I have never seen a case precisely like this. The tumors are callous,—as hard as if they were fibrous in their character. I remember the case of a stage-driver who had forty or fifty tumors of a fatty nature on different parts of his body, while his general health was good, and he lived with his tumors on him until he was eighty years of age, and then died of something else. There is another kind of tumor, called neuroma, which may be diagnosticated by pressure upon it, producing a peculiar sensation similar to that which is felt when the "crazy-bone" is struck.

The tumors in this man's case do not yield such sensation, and are probably fibrous in their character.

Now, in relation to diagnosis: first, these are tumors; second, they are benign; third, in regard to their histology, I cannot say until a portion is put under the microscope. My advice is to leave them alone for the present. The man has a good appetite, sleeps well and feels well. If they should pain him, there is no objection to his using a blister; but, as blisters are out of fashion now, he can use a little iodine as a counter-irritant.

Case II.—A little boy 8 years old, with a tumor on his neck. Gentlemen, here, you observe, is another tumor. Is it solid or fluid? It is fluid. You observe the little fellow is pallid; he has not enough red corpuscles in his blood. His parents are healthy. His father does not smoke, and in this respect is a very sensible man. Many a poor child has been sent to his grave by tobacco. There is no man whose system is saturated with tobacco and rum who can have healthy children. If a man must smoke, he ought to have sense enough to go out in the open air, and not live and sleep in a room full of poisonous tobacco-smoke. A man is not fit to be called a man who has to take a pledge to keep from using tobacco or rum. I use neither, but I have taken no pledge except the pledge to do the best I know for myself.

That tumor has fluid in it. You have got pus there. There is not force enough in the boy's system to get up an inflammation. If the little fellow had roses in his cheeks, that tumor would not be there at all. The diagnosis of Dr. Janeway that it is a cold abscess I confirm fully. I remember of having as a student a lesson on the diagnosis of pus by its fluctuation. An old doctor from the country said in the hospital where a tumor was being examined, "You city fellows don't think a country surgeon knows anything, but you are mistaken; you will find as good brains in the country as anywhere. There is pus in that tumor there, deeply-seated pus." The others laughed in derision, but he said, "I tell you there's pus there." One of the surgeons cut down carefully, but did not find any pus. "Give me the knife," says our country friend, and, plunging it in deep, the pus squirted out.

I have a few things more to say pertinent to this case. That little fellow should be turned out to pasture in the country, where he could browse and have plenty of milk and fresh air. The little fellow is too much shut up; too much confined to the house and school-room, where the atmosphere is bad.

There is another thing I want to refer to. One of God's greatest and best gifts which come down to us is the sunlight. No animal or vegetable can be well and thrive unless it gets the sunlight. Never build your house on the north side of a hill; do not surround your house with trees, but locate yourself so that the sun can get at you. The effect of sunlight upon man has been tested by experiment. The barracks of a large foreign city were arranged north-and-south. The soldiers on the north side were fed, clothed, and placed under exactly the same conditions as were those on the south side. Would you suppose there would be any difference in the death-rate? Do you suppose the death-rate on the north side would be greater than on the south? The death-rate was three to one; that is, for every one on the south side there were three on the north side. There was nothing to ascribe the difference of that death-rate to except that there was sun on the south side and none on the north.

Gentlemen, I will give you some more information. This very day a gentleman gave me an account of a very interesting case. You know at the present time the world is crazy on beef-steak. You would suppose that the best service a man could render his Maker was to eat beef three times a day. If they don't eat beef, they take beef-tea, which is a nasty, dirty mess. Old-fashioned beef-soup is good, and I like it very well, but this beef-tea made out of extract of beef is nasty, muddy-looking stuff. Take a child who has scarlet fever and the albuminuria which accompanies it; what kind of food would be best for him? If you had a patient with Bright's disease, what kind of food would you give him? You would give vegetable food,—substances that do not contain nitrogen. Why? Because nitrogen is excreted by the kidneys in the form of urea and uric acid. Suppose the kidneys were sick, would you impose work upon them? You would spare them. When you feed your patient, who has albuminuria, with beef which contains nitrogen, you increase the function of the kidneys, and this is just what you should not do. If you have a diseased organ, the first and most important thing is rest. Well, this case referred to is a little boy, now nine years old. When five years of age, he commenced self-pollution. Though he had been punished again and again, and every expedient resorted to for the purpose of making him break off this practice of masturbation, it was of no avail. On careful investigation, it was found that the boy had been in the habit of eating tenderloin for breakfast, tenderloin for dinner, and tenderloin for supper. He had eaten three tenderloins a day, thus living on nitrogenized diet. The gentleman was a scientific man, and he looked at the urine

and found it loaded with urea and uric acid. The boy was taken off this animal food and put on vegetable diet, and in less than two months he had no desire for and consequently discontinued the fearful practice referred to. This shows you how important it is to look into these things. I believe there is many a case of epilepsy due entirely to the practice of eating too much animal food. I tell you these things now that you may put them in your memorandum and keep them, as they are important practical hints which you cannot get from your text-books.

TRANSLATIONS.

MEDICAL PROPERTIES OF CANTHARIDES.—Dr. Alessandro Cantieri contributes to *Lo Sperimentale*, October, 1874, an important article upon cantharides. Experiments performed upon various animals (dogs, rabbits, frogs) lead him to the following conclusions:

1. Cantharides introduced into the economy alters the blood-mass, disintegrating and contracting the globules if placed immediately in contact with them, and contracting them alone if the contact is only made through absorption.

2. It diminishes the contractile force of the heart and the vascular walls, and hence lessens the arterial tension. It augments the frequency and rapidity of the cardiac movements, increases the temperature, causes loss of nutrition and general enfeeblement,—phenomena which indicate a real and especial fever.

3. Cantharides produces hyperæmia by blood-stasis in the various organs, and, if the dose is large, gives rise to true inflammations. According to these experiments, it is certain that it excites hyperæmia of the brain and spinal cord; softening to a slight degree in the former, but more decided in the latter. This softening in the cord is more marked in the dorsal and lumbar enlargements, particularly in the latter, where it may give rise to paralysis of the lower extremities. This is observed in dogs, rabbits, and frogs; in the latter there occurs, besides, entire loss of reflex activity.

4. The meninges are the seat of hyperæmia always more marked at the base of the cranium, and particularly where it supports the medulla oblongata. It is this, probably, which, in dogs and rabbits, gives rise to the great frequency of respiration and acceleration of the circulation, with occasional intermittences, which have been observed.

5. The hyperæmia always brings about inflammation of the genito-urinary apparatus, either desquamative or parenchymatous nephritis, with presence of albumen in the urine. It causes venereal excitement, and may give rise to abortion.

6. Cantharides administered internally causes, besides all the morbid alterations mentioned, a true gastro-enteritis, with extensive congestion and ulceration of the gastric mucous membrane, accompanied by a secretion of yellow mucus. Sometimes, when injected into the veins, it does not cause ulceration, but congestion of the gastro-intestinal mucous membrane, with diarrhœa. This occurs frequently in dogs, rarely in rabbits.

These conclusions stated, it remains to apply them in practical medicine; and this is attempted by Dr. Cantieri. His experiments and observations, which have been made on a great number of patients and with a great deal of care, throw considerable light upon the subject. His very conscientious study of the subject terminates by indications for the employment of the vesicatory, and finally by the following conclusions:

After having remarked that blisters should be allowed to remain applied during as short a time as possible, that they should not be made use of in the case of nervous and delicate subjects, in dropsical subjects, particularly in those cases where the anasarca is dependent upon renal disease, in infectious diseases, cholera, or chronic cardiac affections, he adds that the application of blisters of cantharides can only be of use in medicine for their rubefacient action in simple venous hyperæmias or stases, as in those caused by insolation or abuse of alcohol, in simple cardiac affections, and in other diseases of the same kind.

If Dr. Cantieri gives us these indications, it is because he has recognized that cantharides, applied as a blister, debilitates the action of the heart and of the vessels, instead of exciting them; that other stimulants, administered internally, are much preferable; that it causes hyperæmia of the kidneys, active and passive; and that in diseases of these organs it should be entirely banished from use, as well as in cardiac affections,—above all, where albumen is found in the urine. The blister should not be employed, he remarks, in the substitutive method, since, besides its local action, it possesses an absorptive, which may have grave results. It may be employed as a rubefacient in the cases above mentioned, but sinapisms and hot foot-baths present fewer inconveniences.

In acute diseases, in typhoid and other infectious fevers, where adynamia and ataxia prevail, its use should be guarded, since by absorption of the principles of the cantharides, which alter the blood-globules and diminish the contractile force of the heart, infection is piled upon infection. In addition, cantharides alters the cerebro-spinal axis, and therefore brings about disorders in the vital functions depending upon it. It augments inflammations and produces blood-stasis, for it arrests the contractility of the vascular walls and paralyzes the vaso-motor nerves, or rather is active in changing the products of inflammation by altering the crasis of the blood. Finally, it favors cardiac collapse, in place of preventing it, as is generally believed.—*Bull. Gén. de Thérap.*, November 30, 1874.

THE WET SHEET IN SCARLATINA (*The Lancet*, November 14, 1874).—Mr. John Taylor believes that the wet sheet affords the best *external* means for eliminating scarlatinal poison and preventing destructive sequelæ. It promptly suppresses pyrexial heat and itching; produces sleep, with a soft secretive skin, more or less continuously; and enables the digestive organs to accomplish that great desideratum in the treatment of scarlatina,—viz., absorption of highly nutritious food. It may be repeated, on the recurrence of the febrile paroxysm, two, three, or four times in twenty-four hours, the patient remaining enveloped from half an hour to an hour. Mothers and nurses who have witnessed its efficacy are most earnest in its repetition. His plan of procedure is to immerse a nightgown, slit up at the front, in hot water (half a pint to a pint), pure, or medicated with a drachm or two drachms of tincture of capsicum, or in the infusion of three or four pods; or in mustard-water, the clear supernatant fluid from a tablespoonful of mustard to a pint of water; extending the gown over the feet by means of a towel immersed in the same fluid, both to be well wrung out and suddenly applied, and the patient quickly packed in two blankets previously placed on the adjoining sofa or bed; another blanket, or two pillows, or an eider-down quilt, covering all.

He does not intend this treatment to exclude the ordinary forms, but believes that if it is judiciously incorporated with them it will be the means of saving many lives that would otherwise be lost, and of diminishing the duration and severity of the sequelæ.

PHILADELPHIA
MEDICAL TIMES.
A WEEKLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

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EDITORIAL.

PROF. ERICHSEN'S ADDRESS ON AMERICAN SURGERY.

WE suppose that there is not a reader of this journal who has not been gratified at the hearty recognition by Mr. Erichsen of the true position of American surgery.

Considering the brief stay which was made by the Professor, his assertions as to facts are singularly correct, as his deductions are certainly very sagacious. There are, however, a few points which a longer tarry would have given him more light upon. First among these we note, "With the exception of hospitals for the diseases of women, I know of no special hospitals in any of the large American cities." Confining our attention to Philadelphia alone, there are the Wills Hospital for Diseases of the Eye, and the Orthopædic Hospital, both of them very active and very flourishing institutions. Moreover, the University Hospital may be looked upon as a congeries of special hospitals, since it is largely composed of special wards, attended by specialists, for diseases of the eye, of the ear, of the skin, of women, and of the nervous system.

Antiseptics are probably used in this country more extensively than Mr. Erichsen believes them to be: at least, so some of our prominent surgeons state.

The museums of this country are not in the "undeveloped" condition which Mr. Erichsen represents them to be in. So far from those of this city being inferior to those of Boston, that of the University of Pennsylvania alone is much superior to anything of the sort in the country north of Washington, whilst the museum of the Pennsylvania Hospital is itself probably equal to the Boston collection. Unfortunately, the University museum was packed up, *in transitu* from the old to the new building, during Mr. Erichsen's visit: otherwise he would probably have been as much pleased at its richness as he was with other features of American surgery.

WE copy from the Annual Report of the State Hospital for Women and Infants:

"The Board desires to correct a misapprehension which, doubtless, exists to some extent, that the object of the institution is the care and shelter of the deliberately vicious; but the following provisions of the By-Laws will correct that error:

"'No applicant shall be received unless she be clean and free from contagious disease.' 'No unmarried woman shall be admitted to the Lying-in Hospital except for her first confinement.'"

We commend most highly this charity, whose object is to rescue from a life of sin and infamy those who have been led astray. There have been seventy children born in the institution, and as yet no death of a patient.

THE *London Doctor* says to its subscribers who are in arrears, very emphatically, Pay up! and threatens, first to publish the names in its own columns, then to hand them to the protective trade associations, so as to ruin their credit, and finally to sue all parties.

RULE OF THREE.—A problem for any one interested in institutions adhering to the mediæval system of medical instruction: Harvard Medical College, first year, new class, 29; second year, new class, 51; third year, new class, 106. What will the tenth class be?

CORRESPONDENCE.

MEDICAL DOINGS IN BALTIMORE.

AT the regular meeting of the Medical and Surgical Society of Baltimore, held on the 10th instant, Dr. Morris related a case of *placenta prævia* to which he was called by the attending physician. The lady was only eight months advanced in pregnancy, and had had several floodings. At the time of confinement delivery was effected with forceps, and Dr. Morris was called in on account of *adherent placenta*. The doctor said he had seen a number of these cases, but never one like this. The placenta was nearly all detached,

but a small closely-adherent portion, which they were unable to remove, was firmly attached to the posterior surface of the uterus. After delivery there were several gushes of blood, but the injection of liq. ferri subsulph. checked the flow. The lady died three days after, from anæmia.

Dr. Uhler asked whether transfusion would not have been useful.

Dr. Morris said that it would have been justifiable, but that he had read all the cases of transfusion reported in the journals during the last year, and he doubted the efficacy of the proceeding.

Dr. Evans was of the opinion that if loss of blood was the cause of death, transfusion would have been eminently proper.

Dr. Erich thought that the absence of a person with the necessary experience and instruments was to be deplored, and hoped some one would prepare for emergencies of this kind. Dr. Morris was right in regard to the failure of cases of transfusion in which lamb's blood was used, but with human blood several cases have succeeded.

Dr. Seldner had seen the operation performed several times in Vienna, but it had failed in every instance. Hebra performed it in a case of burns, and Späth tried it after Cæsarian section.

A number of members then engaged in the discussion, touching more especially upon the kind of animal from which the blood was taken and the class of cases likely to be benefited by the operation. It was thought to be worthy of trial in cases of hemorrhage, but useless in phthisis and other debilitating diseases, especially as it could not be used until all other means had failed.

Dr. Morris read an interesting paper on "*Pelvic Cellulitis.*" He said the disease was known to the ancients, and was described by Paul of Ægina, but that we are most indebted to Doherty, of Galway, and Churchill, of Dublin, for a careful investigation of the subject. Sir J. Y. Simpson pursued the inquiries, and much enlarged our knowledge, and to him we owe the name now used. It has received various names by different authors,—viz., abscess of uterine appendages (Churchill); parametritis (Virchow); perimetritis (Byford); peri-uterine cellulitis (Thomas). The doctor proposed to follow Simpson in his description of the disease, but he should be compelled to differ with the authorities on several points. First, in regard to frequency. In a practice of twenty-nine years, embracing over two thousand cases of labor, he had met only two cases in which the symptoms were as described. He had met a number of cases of pelvic peritonitis, and had at times been almost disposed to agree with those who deny the existence of cellulitis. As to the seat of the disease, it may be in any of the parts surrounding or adjoining the uterus. McClintock says it is usually in the broad ligaments. There is an immense amount of cellular tissue in the pelvis upon which the disease can vent its force. The products of the inflammation are serum, pus, coagulable lymph, and sloughing cellular tissue. The disease may be found in married women who are childless, and even in virgins, but it is usually met with from three to ten days after delivery. The English do not separate pelvic cellulitis from psoas, iliac, and peri-rectal abscess; while the French, with Nonant at their head, recognize only inflammation of the broad ligaments as entitled to the name. But few cases are met with uncomplicated by disease of the cellular tissue of the broad ligaments. Parturition, abortion, excessive sexual intercourse, cold, blows, etc., may act as causes of the disease. He thinks pessaries may with great propriety be added to the list (case in the October number of *Obstetrical Journal*, produced by a pessary). Parturition and abortion produce about two-thirds of the cases, but it may result from any operation on or injury to the pelvic organs. Dr. M. has seen great constitutional disturbance and inflammatory fever result from the introduction of a tent. It may occur at all ages; and even in the male it may follow operations on the pelvic contents. There is such a case reported in the *Lancet* for November 21. In regard to the seat, McClintock found the right iliac region affected in twenty-seven cases, the left in thirty-four, both in three, and eight supra-pubic. The disease may usually be recognized by vaginal or rectal examination, making pressure with the other hand upon the hypogastrium. The principal guides are pain, tenderness, and constitutional disturbance. Hæmatocele, fibrous tumors, and pelvic peritonitis are the only affections likely to furnish any difficulty of diagnosis. He is convinced that many cases of pelvic peritonitis are called cellulitis. It rarely becomes chronic, as chronic pelvic abscess is one of the results rather than one of the stages of cellulitis. Suppuration may occur in a few days, but usually does not for two or three weeks. The prognosis is usually favorable, so far as life is concerned. Simpson says that tubercular disease of the peritoneum may be set up. Treatment: Before effusion, leeches to hypogastrium, perineum, and anus; warm fomentations, opium, and sedatives; aconite to quiet heart's action; hypodermic injections of morphia; anodyne suppositories and absolute rest. He is not much in favor of mercury, as it is likely to do harm in scrofulous women. Dr. Hintze, of this city, gave mercury and opium, in cases of parturition, to forestall and arrest inflammatory action. Blisters, as a general thing, are not advisable; and purgatives should never be used; the rectum should be unloaded by enemata. The diet should be light and altogether fluid, as milk, beef, broth, etc. After suppuration, the aspirator can be used advantageously.

Dr. Erich said that Dr. Morris laid great stress on pessaries producing the disease. Would he condemn them on that account?

Dr. Morris replied that pessaries can produce it, but not usually; he would not condemn them for that reason only.

Dr. Montmonier saw a case of cellulitis in which part of the pus was evacuated below Poupart's ligament, the other portion pointing in the perineum.

Dr. Lynch has never had a case of post-partum cellu-

litis, but had had two cases of ante-partum. In the first case he was called to attend a woman supposed to be in labor. Upon making an examination, he found a swelling to the left of the os, and there was a discharge of an immense quantity of pus. He gave opium and washed out the vagina. The woman was confined two weeks afterwards, and did well. The second case was a similar one. He was called to attend a woman supposed to be in labor. On examination, a tumor was detected on the left side of the cervix. He gave full doses of opium, and the woman went on for three weeks, when labor came on, and, during a severe pain, the tumor burst, and the vagina was flooded with pus. He had to perform craniotomy. The woman got well.

Dr. Seldner remarked that, in Vienna, Prof. Braun usually punctured these abscesses: in some cases, through the vagina; in others, through the abdominal walls.

The Medical and Chirurgical Faculty held a special meeting on the 4th instant, to take action on the death of Dr. Gerard E. Morgan, who died very suddenly from heart-disease, on Nov. 30. He was a fine physician, and for many years an active member of the American Medical Association.

Yours, etc.,

MEDICUS.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR SIR,—Will you allow me a few lines in your valuable journal, in order to say how interested I have been in a communication by my friend J. G. Richardson, M.D., "Microscopist to the Pennsylvania Hospital," entitled "Notes on the Performance of Two One-fiftieth Objectives"?

Moreover, you will see that I have been complimented therein; and, as I never could bear *such* honors otherwise than gratefully, I beg just a word in friendly reply.

If my memory is not at fault, we have heard before of the peculiar properties of these lenses, especially of "my one-fiftieth dry, made by Powell and Leland," and of "my one-twenty-fifth immersion, made by Wales," and I think these historic objectives enabled their owner, by "long study and constant practice," to detect a skin on the blood-corpuscles, brief accounts of which optical triumph have come to us in the journals of this and other countries, and also in the proceedings of societies which indulge occasionally in the dissemination of useless knowledge.

I was naturally, perhaps justifiably, interested, then, when these two superior lenses, and another doubtless as good, were "tested" by an expert, and the result published for our information.

It is to be regretted that Dr. R. did not define more clearly the special optical and mechanical peculiarities of these lenses, for they are nationally dissimilar, and when he writes of their special performance he leaves the impression that inexcusable defects exist either in the lenses or in the manipulator.

Let us see. "The pleurosigma angulatum offered no difficulties;" of course not, with a one-fiftieth. Yet was it resolved, or were only lines seen? A good four-tenth resolves it into *dots* by central light easily.

Surirella gemma, recommended by Hartnack as a test for high powers, measures, on an average, one-two-hundred-and-fortieth of an inch, longer diameter. The transverse lines are seventy-two in the one-thousandth of an inch; the longitudinal, eighty-four to the one-thousandth. The "basket-like arrangement of these lines, produced, according to Hartnack, by elongated hexagonal areolations," and which Dr. R. says "came distinctly into view in a noteworthy way," is a misinterpretation of structure, as proven long ago by Dr. Woodward and Mr. Moorehouse, who, with others, resolve them into dots, and under lower powers than the one-fiftieth. The separation of lines or dots only eighty-four thousand to the inch is not the limit of best modern lenses, but they do lie on the border-line of unpractised illumination, and hence Dr. R. did not accomplish resolution in Surirella.

When these lenses were turned on the Amphipleura pellucida, only the "markings near the edges of the frustules" were seen, and the Boston one-fiftieth did the best work. In well-defined words, the test was not resolved at all, only seen, like most microscopical work. In the hands of Prof. J. Edward Smith, a Tolles dry—and *very* dry—one-eighth resolved the amphipleura into beads; and, with lowest eye-piece, both sets of striations were easily seen. (See *Mon. Mic. Jour.*, September, 1873.)

We are told next how the Podura scale (what species?) looks under high power, by *central* light. On some good specimens of the doctor's own mounting, we are informed that "the definition of the exclamation-marks is somewhat superior" under the Boston lens to that under "the one-fiftieth made by Powell and Leland, and the immersion one-twenty-fifth made by Wales." How much superior? What was the character of this definition by *central* light?

Here the histologist is interested, and naturally wants to learn whether these high-power lenses will help him in his honest work. If this central-light definition was so *inexpressibly* bad, what were the aberrations?—negative, or positive? How shall we judge from the accounts? Which is it don't define?—the lens or the—oh, I *won't* think it! However, in optical fogs like these, discoveries have been made. Neither bears the C eye-piece "without marked loss of definition."

We have bad definition, again, on the salivary corpuscles,—at least we infer from the account that the molecules were nebulously revealed by all the lenses. The salivary corpuscle is an easy test for definition, a good one-fifth showing every morphological element with vivid distinctness.

These high powers, however, reach their climax on the Bacterium. These organizations were "limited by a delicate hair-line, almost as fine as can be drawn by an ordinary writing-pen." This is better work, and a clearer report. Is it not strange that the same lenses

which cannot define the test podura or molecules in salivary corpuscles should come up to hair-lines in Bacteria? There may have been some special force operative here, which only the initiated can understand.

"In order to overcome the insuperable obstacle which has hitherto prevented a one-fiftieth being tested in Philadelphia, I have devised the following method, etc.,"—covering the object with thin mica. This is too fast. In the aboriginal days of microscopical technology, mica was used in lieu of glass (and it is still employed by some who are content with approximations), but was abandoned. It is not homogeneous, like good glass, and is so easily scratched that misinterpretations were unavoidable by inexperienced observers. If those Bacteria were seen through mica, I can understand the hair-lines, and "cylindrical lenses," and all the rest. Moreover, the old plan as now revived as original is exceedingly clumsy, and presents the insuperable impediment of two thicknesses of glass beneath the object, which would interfere with *best* illumination. The step is retrograde, and, compared with slides covered with thin glass by Möller,—thin enough for the one-fiftieth,—and which have been in our hands for several years, would be useless.

Finally, Dr. R. acknowledges these high powers are "not quite achromatic." Opticians do not seek to remove *all* color from their high combinations; they think best definition is secured by deficient compensation in the flint-glass systems; some allow the flint to preponderate. But Dr. R. does not tell us where this color appears,—within or without the focus,—nor what region of the spectrum is robbed to complete the picture.

My only object in writing is to bear my insignificant testimony against such testing of lenses, and to discountenance general microscopical platitudes, because they enfog beginners with chromatic haze, conveying the unmeant impression that the truth has been uttered, whereas only fragments and torn patches of the garment of the immortal goddess have been held up to view.

J. G. H.

PROCEEDINGS OF SOCIETIES.

MEDICAL SOCIETY OF THE COUNTY OF ALBANY, NEW YORK.

SEMI-MONTHLY MEETING, NOV. 25, 1874.

DR. JAMES S. BAILEY, PRESIDENT, in the chair.

EPULIS OF THE LOWER JAW.

DR. LEWIS BALCH reported the following case: Thomas Burns, æt. 8, American, admitted at St. Peter's Hospital, October, 1874 (service of Dr. Balch). The mother says that almost a year ago she noticed that one of the teeth on the right side (the canine) had grown inside of its fellow to the left. The incisor was extracted, and a "lump of flesh" grew in its place. This did not increase in size until almost five weeks before admission. At that time the canine was drawn by a doctor, who lanced the "lump." Nothing but blood followed the incision, and since that time the lump has grown quite rapidly. Patient, up to the present time, has enjoyed good health. Family healthy. Patient has been in the habit of picking up cigar-stumps in the street and smoking them, and also of chewing tobacco. Examination shows a dark-colored fungous growth in the right side of the mouth, part in front and part behind the teeth, having its base in the lower jaw. It has pushed before it the incisor teeth, crowding them over the ones adjoining, rendering the teeth very irregular.

Dr. Balch removed the fungous growth, but, owing to the hemorrhage, it was decided not to remove the bone, which was largely implicated, but to allow the patient to recover from the present operation, and then proceed to remove the part necessary for complete extirpation of the growth. The hemorrhage was controlled by pressure with picked lint. Microscopic examination of the part removed showed it to be cancerous in character, characteristic cells being easily found.

October 30.—The patient, having recovered from the first operation, was etherized, and an incision three and a half inches long made along the under edge of the jaw, from a point about an inch and a quarter to the left of the median line, to the right facial artery, which was not severed. The flap thus made was turned up over the mouth, and the bony part of the tumor removed by bone-forceps. The incision was made in the manner stated, so that if the disease was found to extend through the whole depth of the jaw, excision could be performed. It was, however, found unnecessary to excise, hard bone being below the alveolar processes.

Two ligatures were applied, and the wound closed by three hare-lip pins, with intermediate sutures of fine silk. A packing of picked lint was applied on the inside.

November 2.—The pins were removed to-day. There is some swelling of the face, but the patient does not suffer any pain, and is in excellent condition.

November 4.—Four sutures were now taken out. The wound has healed by first intention, almost throughout. The ligatures came away to-day. Inside the mouth the wound looks healthy, with but little discharge. A lotion of nitric acid, ʒi to Oj of water, is ordered as a wash.

November 13.—External wound is entirely healed. Some few pouting granulations are seen springing from the right side of the internal wound, and look suspicious. At the suggestion of Dr. Swinburne, they are touched with chloride of zinc. Patient is around the ward.

November 16.—The exuberant granulations are touched with chloride of zinc. Patient doing well, and wound granulating healthily.

November 18.—Granulations have subsided, and the wound is rapidly healing.

November 23.—Patient nearly well, and left the hospital without telling his intentions.

Dr. THOMAS BECKETT said that from the drawing he recognized the case as having been seen by him in the latter part of last summer. When he saw it there was a tumor of some size, and it had lifted the teeth upward; they were lying, as it were, in the top of the tumor.

Dr. G. H. BENJAMIN said that he had treated a similar case, which was supposed to have arisen from an ulcerated tooth. In lancing it, nothing but blood flowed. A year afterwards, the tumor was developed into a considerable mass on the outer side of the gum.

OPERATION FOR FEMORAL HERNIA.

Dr. O. H. E. CLARK reported the following: Mrs. H., about ten years ago, in lifting a wash-tub, became ruptured, about ten weeks after confinement. Two years later, a severe attack ensued, on lifting a heavy

vessel of water. After some difficulty, the intestine was returned, but no preventive treatment followed. Dr. Clark was summoned in haste in the night, January, 1873. He found a double femoral hernia existing. The left side was of the size of a hen's egg, tense and painful to the touch, and appeared as if an entero-epiplocele.

There was intense pain in the abdomen; pulse 122, weak and small; countenance ghastly, and covered with a clammy perspiration. The voice was weak, and the patient completely prostrated, and seemingly near death. Taxis having failed, gr. ⅓ of morphia was administered, and a large warm linseed poultice, sprinkled with tincture of opium, was applied. This composed the patient, and she slept for an hour or more, when she felt relieved. Taxis was again repeated, and the hernia was returned. The first intimation of the return was a peculiar sensation and gurgle of flatus in the abdomen. The plan operating as successful was that recommended by Malgaigne.

March 20, 1874, Dr. Clark was again summoned. The patient had passed her sixtieth birthday; was very thin, with bad appetite, and suffering from some urinary derangement.

The left hernia was now strangulated, and was large and hard. Vomiting and pain were present. Patient had resorted to her usual method of reduction, and had failed. She was less weakened than at Dr. C.'s first visit. The tumor was about the size of a large goose-egg, and occupied the space intermediate between Poupart's ligament and the perpendicular. When pressed, it gave a sensation like that of a large sausage coiled on itself in a sac under the integuments. It was dull on percussion, and hard to the touch, excepting on that portion near to the ring, where it was resonant on percussion and soft to the touch. The use of morphia and of the poultice, with attempts at taxis, were made a number of times in the next few days. But, all attempts having proved abortive, anæsthesia was produced with chloroform, the effect being maintained with ether. Dr. Featherstonaugh kept her under its influence for more than three hours. Taxis was attempted by all present, and, having failed, a transverse incision of about two inches, and another perpendicular to the first, of three inches, completely exposed the tumor, covered by layers of fascia devoid of adipose tissue.

The doctor departed from the usual manner of procedure, and, instead of dividing the different layers on the director with a scalpel, he made use of a pair of small, sharp scissors, with one of the blades made blunt at its extremity, which, although small, is somewhat square. It was from a case of instruments made for operating on the eye. With these scissors he carefully divided the tissues down to the sac. Dr. Clark was of the opinion that the scissors operated with more precision than the director and scalpel; they enabled him to divide the fascia much more minutely than could have been done with the director passed between the layers and cut down to with a scalpel; and in opening the hernial sac their superiority was manifest. Long directions are given in text-books how to hold the scalpel flatwise, so as not by any mischance to cut the bowel. With the scissors no such accident can occur; and, while they do not exclude the director, on which they may be guided, they may to a certain extent be used without it. The small, blunt, square point will divide layers with much greater minuteness than the director, and without the danger of the sharp cutting point of the scalpel. Before the director can be passed under a layer of fascia, it must be incised with the scalpel, and while doing so with a sharp-pointed instrument an accident might possibly occur. When the sac has to be opened, it can be pouched up and nipped with more precision than can be attained with the scalpel, which is always liable to slip in a little farther than was intended. Again, when the director has been introduced and run along the internal surface of the anterior wall of the sac, if a knife is used from the outside to cut down to the director, or is run along the groove, or if the wall of the sac is lifted from within on the edge of the knife, possibly a piece of the intestine might be opened which has doubled over the director; but if the blunt blade of the scissors is run in the groove of the director, and kept well pressed against the wall of the sac, it can actually be seen, and the operator may feel certain that nothing intervenes between it and the sac in cutting that structure.

The hernial sac was whitish-yellow, thick and tough, and appeared united to the fascia by minute blood-vessels. After having become satisfied that this was truly the sac, the operator requested the assistant to push the contained viscus upward towards the abdomen; he then pinched up a minute fold of the sac and proceeded to open it as described. Serum ran out in large quantities. After the sac was empty and the hernia was returned into the abdomen, the patient was placed in a position favorable to its exit.

An examination of the protruded part showed it to be omentum. From the symptoms and sensation of returning flatus, there was no doubt that some of the intestine was originally extruded, and was returned by taxis. The omental mass was about three inches long by two wide and one and a half thick; it was very pale, and firmly embraced by the falciform border of the fascia lata. All attempts to return it failed.

Hey's ligament, as well as the deeper Gimbernat's ligament, having been divided in the usual manner, then carefully the whole was carried with the finger a little to the right, into the cavity of the abdomen. Even with the free incisions used, considerable difficulty was experienced in returning the mass, from its size, and, at the end of the process, from firm and evidently old adhesions, two of which were severed near the sac, and, as they bled freely, light ligatures of fine silk dipped in carbolic acid solution were tied around them, and, after their ligated and strangulated tips had been touched by the same strong solution, they were introduced into the abdomen.

The second mass, being of considerable size, caused more anxiety,—fearing decomposition and consequent peritonitis, besides the possibility of pyæmia; but it was held that to return it into the abdomen, after a thorough application of carbolic acid solution, was the best thing practicable.

The pulse being weak, the parts were brought together and closed with carbolized sutures, leaving about one-quarter of the perpendicular incision open below, to favor drainage. A few straps of adhesive plaster were put over the superior part of the wound, over which a pledget of lint soaked in carbolic acid was lightly placed, and as lightly retained *in situ* by a bandage.

After reaction, the patient was removed to a bed the feet of which were raised four inches on blocks of wood. A small pillow was put under the thigh. Pulse 110. Ordered morphia, gr. ¼, absolute quiet, and a small piece of ice occasionally. She slept soundly during the night, awakening the next morning heavy, stupid, and feverish; pulse 120, and rather irregular; temperature 103°. Some pain in the abdomen, but she was so oppressed that no connected answers were obtained. Applications of hot carbolized water were made over the abdomen, extending over the inguinal region and thigh, and covering the wound.

These applications were changed every half-hour for the next two days. Diet—beef-tea, milk, and arrow-root, in very small quantities, often repeated. Ordered potassii acetas and potassii nitras, there being a history of urinary troubles.

Second day, 9 A.M.—Pulse 104, extremely weak and irregular; temperature 102.7°; respiration 32; tongue dry. Wound has united by first intention, in the upper or horizontal incision, but the perpendicular cut has not. Its edges are pale, and pus commences to ooze out.

Third day, 10 A.M.—Wound sloughing in all directions, especially invading the abdominal integuments; one and a half inches above Poupart's ligament, slough is very deep. Excised dead tissue freely; took out all sutures and applied charcoal poultices, made with carbolic acid lotion.

Besides beef-tea and milk, ordered 1 gr. quinine, 2½ grs. sulph. soda, and one teaspoonful of brandy, every three hours. Passed one pint of urine in twenty-four hours. 9 P.M., sloughing extended still farther on abdomen. Is very weak; ordered quinine, gr. i every hour, and morphia, gr. ¼ every evening.

Fourth day.—Had a good night's rest; passed a more comfortable day, disturbed, however, by colicky pains. Wound surrounded by a broad, red, erysipelatous border. The edges keep crumbling down, but the bottom of the wound is granulating. Opened an abscess in the lower and deep part of wound. Had wound stuffed with lint cut very fine and steeped in carbolic acid lotion, and packed tight charcoal poultices over the whole. Dressings to be changed every three hours.

Fifth day.—Improving. Pulse 80; temperature 90°; urinates freely; wound looks better. Granulations very flabby. Touched it freely with nitrate of silver, then had it packed with lint soaked in Edinburgh red wash, made with carbolic acid lotion, thus:

Zinci sulph., gr. xvi;
Spt. rosmar., gtt. ii;
Spt. lavand. comp. ad ℥viii.

6 P.M.—While sleeping, felt faint. Awoke cold, dizzy, unable to see out of left eye; limbs numb. Gave brandy, and she revived. In the evening, flushed and feverish. A red and painful spot forming on the left shoulder.

Sixth day.—An abscess formed on the left shoulder, just below the angle of the left scapula; gives great annoyance. Feverish and restless.

Seventh day.—Patient feels worse. A large sinus exists in lower part of wound. Passed in the director and cut down to it from without, and inserted a tape seton. Opened abscess in back, out of which ran very fetid matter. Patient looks weak, yellow, and sunken. Ordered beef-juice and eggs, besides previous treatment. Touched the wound with nitrate of silver, and then packed it with lint dipped in carbolic acid lotion.

Gave starch-water injections to move the bowels.

Eighth day.—Much better; pulse 100. Wound granulating. Approximated edges with adhesive plaster.

Ninth day.—Has vomited, probably from disagreement of food. Had a liquid stool. Wound granulating. Omitted packing; strapped it lightly.

Tenth day.—Improving.

Thirteenth day.—Recovering rapidly.

Sixteenth day.—Wound almost healed; thoroughly convalescent, and in three months the hernia appeared radically cured; but it has since occurred again, and obtained considerable size. In spite of her experience, she will not wear a truss.

The points of special interest are as follows:

1. The reduction of the enterocele under the influence of an anæsthetic, leaving the epiplocele behind. From the symptoms, the peculiar feeling of returning flatus, and subsequent diminution in the bulk of the tumor, there is no doubt of the correctness of this view. After this sensation and sound of returning flatus and of giving way had been distinctly experienced, there occurred what had not taken place before: the tumor became smaller on pressure and larger when suspended, showing that a communication had been established with the interior of the abdomen; also, that the peculiar sensation and sound referred to as occurring in the early part of the taxis were not due to serum passing into the cavity of the abdomen, for such did not occur whenever that took place. The strangulated piece of bowel need not have been large. In Gross's Surgery there is mentioned a case where the protruded intestine was not larger than a peanut deprived of its shell.

2. The size of the tumor. Femoral hernia is stated, as a rule, not to exceed an almond in size. This case shows an exception.

3. The large amount of serum. Only a few drachms are generally found in femoral hernia. In this case, at least eight drachms flowed away. The returning into the abdomen of the serum when the hernia was subjected to pressure, thereby considerably diminishing its bulk, and leading to delusive hopes of its reduction, is a peculiarity not mentioned by authors, and worthy of being remembered, as it might lead to an undue prolongation of the taxis, to the great injury of the patient.

4. The temporary radical cure of the hernia, following on the extensive sloughing that resulted from the manipulation and operation, and which might probably have become permanent had the patient been more governable and had she steadily worn a truss.

Dr. Clark asked how long the operation should be deferred. He believed the answer to the question was becoming more unanimous, that the moment the physician feels satisfied that taxis is not likely to succeed, and when the patient's symptoms progressively increase in severity, then, without waiting and subjecting the patient to dangerous manipulations, the operation should be performed.

The surgeon should always keep clear in his mind that but one cure exists,—the return of the intestine into the abdominal cavity,—and that every moment it is out is not simply a moment lost, but that increased danger is incurred. The circulation in the strangulated portion is at first impeded, and later altogether arrested, and the involved intestine is marching surely to gangrene, and the patient to death. In other diseases there may be a time of suspension, during which it may be prudent to avoid heroic measures; in them, time alone is not a source of danger; but here, unless reduction is made, the patient dies.

Another important point to keep in mind is, that reduction at any time will not save: it must be reduced while the intestine or omentum is yet in a fit state to live, and not to produce inflammation of the peritoneum when returned. He did not mean to condemn a scientific, persevering taxis, but the rough practice of continuing beyond the limit of safety, either as to the force used, the severity of the symptoms, or the valuable time consumed during which the patient might be saved were the operation performed.

Let us inquire, now, whether the operation, if performed in time, when the system and parts are in a condition in which recovery after any operation is expected,—whether the operation, thus performed, is fraught with the great danger which has so long made it a terror to the profession, or whether this estimation has not arisen from the operation being deferred until too late, and therefore followed by fatal results. It is believed by surgeons who have had most experience in operating under favorable circumstances, that the mortality of patients is materially diminished in such cases. Holmes's System of Surgery, the standard exponent of cotemporaneous British surgeons, says, "We believe that death resulting from strangulated bowels would be a rare occurrence if it were practicable to return every strangulated enterocele within twelve hours after the commencement of the symptoms, even assuming that the

cutting operation be required to accomplish that end in every case." Sir James Paget, in his lectures on strangulated hernia, strongly urges his auditors to operate in all cases of hernia which have become totally irreducible, if vomiting continues at intervals, even if no other symptom seems to call for active interference; and he adduces numerous cases to prove the propriety of the rule. On another occasion he says, "I have no doubt that for every case in which an operation has been avoided by waiting, there have been two cases in which lives have been lost by waiting too long."

Sir James Paget has operated about one hundred times for strangulated hernia, and has had a large experience in this surgical lesion.

J. Cooper Foster, Surgeon to Guy's Hospital, says, "Make, then, one decided attempt, under chloroform, and, if you fail, operate. You cannot hear this too often, because forcible taxis and delay in operating are the great causes of death of all cases in our hospital. If I myself had a rupture, no one should try to reduce it except the operator, with the proviso that if he failed after a very moderate attempt, he should at once proceed with the knife."

T. Legros Clarke, Surgeon to St. Thomas's Hospital, holds "that the fatality of our cases is chiefly due to delay and the repetition of unsuccessful attempts at reduction by taxis. I am satisfied," says he, "that the risk attending an operation for strangulated hernia is very much aggravated. If gentleness and forbearance were more generally adopted in applying the preliminary measures undertaken to afford relief, and purgatives and procrastination (often self-inflicted) were eliminated from the treatment, I believe that the statistics of the operation for strangulated hernia would present a far more favorable aspect than is at present the case."

Dr. Frederick Hyde, in an article on hernia and its complications, published in the Transactions of the Medical Society of the State of New York for 1867, warmly advocates early operation, even, in many instances, after only fair trial of the taxis, in which advantage of all adjuvant means has been taken. The writer terminates his treatise thus: "It is objected, to an early division of the structure, that it is too spoliative a measure, and is in conflict with the doctrines of conservative surgery. We submit whether it does not savor altogether more of a justifiable conservatism to carefully divide the ligating tissue and relieve the already injured structure, than to repeat the trial to reduce them while we have the remaining unyielding structure." He is confident "that he has never seen a patient die on whom this operation has been made, from its own legitimate results, and his recollection assures him equally well that the fatality has been from the injury sustained by the parts before the incisions were made."

In these days of daring surgery, when the peritoneum —that cavity hermetically sealed to art by the fears of old surgeons—is boldly incised into for inches to withdraw therefrom an enormous cyst, fearlessly cutting away adhesions,—in these days, he says, herniotomy has lost its terrors, and surgeons at present generally agree that the fatal risk is not incurred in performing this operation, but in doing so too late. When a man is moribund, or surely going that way, operations are superfluous; and, blinded by delusive hopes of at length succeeding with taxis or other means employed, the surgeon too often allows his hapless patient to slip into that state in which all assistance is in vain.

Dr. MARCH spoke in praise of the paper read by Dr. Clark, and referred to the rarity of double femoral hernia. He was of the opinion that the dividing of the tissue with blunt scissors was a decided improvement. He did not favor the idea of employing taxis long, but believed in operating early.

Dr. HANNON and others gave their views, which were essentially the same as those already expressed.

GLEANINGS FROM OUR EXCHANGES.

A REMARKABLE CASE OF PHLEBITIS (*Archives of Ophthalmology and Otology*, vol. iv. No. 1).—R. Wreden reports the case of a boy, æt. 15, who suffered from a terrible inflammation of the cerebral sinuses, caused by an acute inflammation of the middle ear, which had the characteristics of an ostitis of the temporal bone.

After a slight improvement, the patient caught cold, and the inflammation of the sinuses returned with increased violence; high fever, with frequently recurrent rigors, continual nausea, with very frequent vomiting, giddiness, tinnitus, great weakness, apathy, somnolence, delirium, epileptiform convulsions, etc. The differences in these symptoms are all explained by the rapid spread of the inflammation of the sinuses from the right transverse sinus to the others.

Phlebitis of the internal jugular vein made itself known by enormous painful swelling of the corresponding side of the neck, without redness of the skin. The face was puffy and œdematous. There were clonic and tonic spasms of the sterno-cleido muscles, from irritation of the spinal accessory nerve in the jugular foramen. The phlebitis of the superior longitudinal sinus was marked by two symptoms of importance: repeated violent epistaxis, and epileptiform convulsions. These were due to the excessive choking of the blood-current from the surface of the brain. The affection of the right sinus cavernosus was manifested by phenomena of irritation and paralysis of the abductor nerve, the first branch of the fifth, and the oculomotor, and by phenomena indicative of blocking of the circulation in the eye.

The affection of the abducens, which came close to the outer wall of the cerebral carotid artery in the cavernous sinus, was indicated by internal strabismus of the right eye,—*i.e.*, paresis of the external rectus. Pressure on the first branch of the trifacial caused unilateral headache, photophobia, etc.; pressure on the oculomotor caused ptosis. The symptoms of ischæmia of the eye were strongly marked, and consisted of œdematous swelling of the eyelids, of the conjunctiva of the eyeball, and the retro-bulbar connective tissue (exophthalmos).

The patient made a good recovery, the treatment having consisted of leeches, poultices, laxatives, and the administration of proper nourishment.

PROBABLE LEAD-POISONING FROM A BULLET LODGED IN THE KNEE-JOINT (*The Boston Medical and Surgical Journal*, November, 1874).—At a recent meeting of the Boston Society for Medical Improvement, Dr. Ellis reported the case of a man who had severe attacks of colicky pain in the abdomen, always preceded by obstinate constipation, and accompanied by vomiting. He subsequently had epileptic convulsions, became violently delirious, and died. About six weeks before his death, a blue line was noticed on his gums.

As it was known that twelve years previous the patient had been wounded in the knee, search was made, and a large conical leaden bullet was found imbedded in the inner condyle of the femur, its base being exactly level with the articular cartilage, its longest diameter parallel with the shaft of the bone between the two condyles. There was, therefore, a surface of

lead exposed to attrition, in a synovial cavity, where there was a constant secretion and absorption of fluid, and it would seem that there might have been absorption of some soluble salt of the metal.

PURPURA HÆMORRHAGICA (*The Lancet*, November 14, 1874).—Dr. W. B. Richardson divides purpura hæmorrhagica into three classes, distinct in their etiology, diagnosis, and treatment; the *aqueous*, in which the water of the blood is in excess, and the colloids relatively decreased; the *saline*, where some saline substance holds the colloidal fibrin in undue solution; and the *vascular*, where there is a degenerative change in the capillaries, and rupture or transudation is facilitated. Dr. Richardson believes that the character of the eruption varies in these several forms.

NOTES AND QUERIES.

THE NEW SCRIPTURES,

According to Tyndall, Huxley, Spencer, and Darwin.

(Genesis, Chapter II.)

1. PRIMARILY the Unknowable moved upon cosmos and evolved protoplasm.

2. And protoplasm was inorganic and undifferentiated, containing all things in potential energy; and a spirit of evolution moved upon the fluid mass.

3. And the Unknowable said, Let atoms attract; and their contact begat light, heat, and electricity.

4. And the Unconditioned differentiated the atoms, each after its kind; and their combinations begat rock, air, and water.

5. And there went out a spirit of evolution from the Unconditioned, and, working in protoplasm by accretion and absorption, produced the organic cell.

6. And cell, by nutrition, evolved primordial germ, and germ developed protogene, and protogene begat eozoon, and eozoon begat monad, and monad begat animalcule.

7. And animalcule begat ephemera, then began creeping things to multiply on the face of the earth.

8. And earthy atom in vegetable protoplasm begat the molecule, and thence came all grass and every herb in the earth.

9. And animalcula in the water evolved fins, tails, claws, and scales; and in the air, wings and beaks; and on the land they sprouted such organs as were necessary as played upon by the environment.

10. And by accretion and absorption came the radiata and mollusca, and mollusca begat articulata, and articulata begat vertebrata.

11. Now these are the generations of the higher vertebrata, in the cosmic period that the Unknowable evoluted the bipedal mammalia,

12. And every man of the earth, while he was yet a monkey, and the horse, while he was a hipparion, and the hipparion, before he was an oredon.

13. Out of the ascidian came the amphibian and begat the pentadactyle, and the pentadactyle by inheritance and selection produced the hylobate, from which are the simiadæ in all their tribes.

14. And out of the simiadæ the lemur prevailed above his fellows and produced the platyrhine monkey.

15. And the platyrhine begat the catarrhine, and the catarrhine monkey begat the anthropoid ape, and the ape begat the longimanous ourang, and the ourang begat the chimpanzee, and the chimpanzee evoluted the what-is-it.

16. And the what-is-it went into the land of Nod and took him a wife of the longimanous gibbons.

17. And in process of the cosmic period were born unto them and their children the anthropomorphic primordial types.

18. The homunculus, the prognathus, the troglodyte, the autochthon, the terragen—these are the generations of primeval man.

19. And primeval man was naked and not ashamed, but lived in quadrumanous innocence, and struggled mightily to harmonize with the environment.

20. And by inheritance and natural selection did he progress from the stable and homogeneous to the complex and heterogeneous; for the weakest died, and the strongest grew and multiplied.

21. And man grew a thumb, for that he had need of it, and developed capacities for prey.

22. For, behold, the swiftest men caught the most animals, and the swiftest animals got away from the most men; wherefore the slow animals were eaten, and the slow men starved to death.

23. And as types were differentiated, the weaker types continually disappeared.

24. And the earth was filled with violence; for man strove with man, and tribe with tribe, whereby they killed off the weak and foolish, and secured the survival of the fittest.—*Cincinnati Commercial.*

IMPROPRIETY IN AWARDING THE CERTIFICATE OF THE PHILADELPHIA HOSPITAL (BLOCKLEY).

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR SIR,—I am credibly informed that to the students of the dental colleges of this city who attend the bi-weekly clinics of the Philadelphia Hospital (Blockley) is awarded the formal diploma or certificate of the institution, equally with the graduates of the regular medical colleges. Of the impropriety of this course there can be no doubt. As a certificate of attendance on clinical lectures at a general hospital, bestowed on medical *graduates*, little as such a document may really mean or be deserved, I do not now question its propriety. The certificate simply implies that the graduate, in addition to his ordinary collegiate course, has had at least some clinical opportunity at a general hospital. With regard to dental students, it may speciously imply a knowledge of the general subjects of clinical teaching, which, with their special and limited didactic course at the dental colleges, they cannot properly possess.

That the certificate of the Philadelphia Hospital, when thus loosely broadcast, is liable to abuse in being used as a guarantee of knowledge fitting its possessor, who is not a medical graduate, for the practice of medicine and surgery, is evident.

The clinics of general hospitals have but little bearing on dentistry, and there was never a general attendance of dental students at hospital clinics until the showy prize of the hospital certificate was promised to them at the Philadelphia Hospital. Now the dental students, in view of the expected pretentious document, attend that hospital in a body, with the distinct object, as several of them have asserted to me, of obtaining a certificate which no other hospital will give them.

If the rule of granting certificates of general hospitals to no others than medical graduates, and only on presenting evidence of such graduation, is to be departed from, a dangerous precedent of transgression will be established.

In another view of the matter, a hospital certificate that has become attainable without medical graduation will soon sadly depreciate in value.

The provincial doctor who adorns his office with the certificate of the Philadelphia Hospital will, on discovering a similar document emblazoned on the front door of the village tooth-drawer, be inclined to hang his depreciated testimonial out of sight.

I would not have the clinical opportunities of the dental student in any manner restricted, but he should not be awarded a credential that ought to be attainable only after medical graduation. To use the language of a good dental as well as medical authority, Dr. Garretson, in his recent article in your journal, "A specialist should not be received into the *common brotherhood* of medicine without his coming to a common platform as regards all that makes the *doctor*."

I am quite sure that the ethical bodies of our profession will agree with me that hospital certificates should be absolutely restricted to graduates of regular medical colleges, and that a contrary course must render the medical board of a hospital amenable to indictment of censorship.

VINDEX.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM DECEMBER 15 TO DECEMBER 21, 1874, INCLUSIVE.

COOPER, GEO. E., SURGEON.—Relieved from duty at Benicia Barracks, California, and assigned to duty at Point San José, California. S. O. 124, Department of California, Dec. 11, 1874.

BENTLEY, E., ASSISTANT-SURGEON.—When relieved by Surgeon Cooper, to report to the Medical Director at these Headquarters for duty. S.O. 124, c. s., Department of California.

WHITE, R. H., ASSISTANT-SURGEON.—Granted leave of absence for one month. S. O. 208, Department of the Gulf, Dec. 16, 1874.

PAULDING, H. O., ASSISTANT-SURGEON.—Assigned to temporary duty at Fort Snelling, Minnesota. S. O. 275, Department of Dakota, Dec. 14, 1874.

SEMIG, B. G., ASSISTANT-SURGEON.—Assigned to duty at Camp Halleck, Nevada. S. O. 124, c. s., Department of California.

DE LOFFRE, A. A., ASSISTANT-SURGEON.—To report in person for duty to Colonel N. A. Miles, 5th Infantry, commanding Indian Territory Expedition. S. O. 205, Department of the Missouri, Dec. 10, 1874.